Can we do implementation better?

Applying evidence to the implementation of new programs and innovations in Aboriginal and Torres Strait Islander health care

Roundtable Report

Brisbane, March 2013

Jenny Brands, Luella Monson-Wilbraham, Alana Gall, Kate Silburn
and the roundtable participants

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Introduction

This roundtable was held as part of the Implementation of Innovations in Aboriginal and Torres Strait Islander Health Care project commissioned by the Lowitja Institute. The project aim was to help us learn about how to apply evidence to the process of implementation – helping us do implementation better.

Australia spends a lot of money developing and testing medicines, technologies, systems and new ways of doing things to improve health care and health outcomes. But we spend very little on developing or testing methods for implementing all these evidence-based products.

The Implementation of Innovations project included three major parts:

• A review of the literature on implementation in health care generally, to identify those aspects of the evidence-base that may be relevant in Aboriginal and Torres Strait Islander contexts.
• A roundtable to test the validity of findings from the literature review against the ‘on the ground’ experience and tacit knowledge of stakeholders and research users.
• Development of two draft tools that may support planning for implementation in Aboriginal and Torres Strait Islander health care.

This report details what took place at the roundtable, including recommendations for further action.

Background

What is implementation?

• Implementation is the process of getting a ‘new better way’ of doing something into routine use.
• Implementation enables a person or organisation to take up the new better way of doing something.

Why is implementation important?

• Money, effort and time are wasted by ineffective implementation of new programs.
• Programs and practices that work well in Aboriginal and Torres Strait Islander health often lapse after pilot programs or research funding ends.
• Doing better at implementation could help ‘Close the Gap’ more rapidly.

What do we know about implementation in Aboriginal and Torres Strait Islander health?

• In terms of an evidence base, not a lot. A recent review found only 14 studies published between 1992 and 2011 that evaluated or described the transfer and implementation of promising programs or innovations in Aboriginal and Torres Strait Islander health (McCalman et al. 2012). But the nature of Aboriginal and Torres Strait Islander health care means that lots of people are doing implementation all the time. Some people and organisations do it very well; others struggle.
• To help build an evidence base about effective implementation, the Lowitja Institute commissioned this research project, Implementation of Innovations in Aboriginal and Torres Strait Islander Health Care.
• This roundtable provided an opportunity to bring together the evidence on implementation and the experiences of implementation of those involved in Aboriginal and Torres Strait Islander health care.
What do we know about implementation generally?

There are a number of principles that emerge from the academic literature as enablers of effective implementation.

Planning

Using a planned and participatory approach to implementation – involving and engaging people from across the organisation/setting(s) in which the implementation will occur, at all stages of the process

Engagement/leadership

Strong engagement in the whole implementation process by leaders and managers.

Building a shared meaning about the change that is being implemented.

Context

Giving adequate consideration to the specific nature and priorities of the local context when planning implementation and reducing any barriers that may impede effective implementation – taking note that local context is influenced by inner (organisational) and external (wider setting) environments and issues.

Strategies

There are many implementation strategies that can be used (see below: Implementation Strategies). There is no magic bullet – strategies need to be selected to suit the change you wish to make, the local context and the resources or capabilities you have.

Using multiple strategies for implementation is likely to be more effective (up to a point).

Adaptation

Adaptability of innovations to suit local contexts in ways that will support adoption without losing core components – including the way that innovations are ‘packaged’.

Capacity

Organisational capacity to take on innovations (also called ‘absorptive capacity’) – this requires human and financial resources, along with facilitation. It includes organisational capacity to be innovative – using implementation as an opportunity to build the longer-term capacity of an organisation or community to create and implement innovations that suit local needs and context.

A sense of self-efficacy or empowerment amongst individuals and groups.

The Roundtable

Leading implementation experts, researchers, policy makers, and on-the-ground implementers of health innovations came together at a national roundtable in Brisbane on 22 March 2013 to focus on the implementation of new programs and practices in Aboriginal and Torres Strait Islander health care.

Aboriginal and Torres Strait Islander Social Justice Commissioner Mick Gooda facilitated the roundtable, which brought together almost 40 international and national stakeholders who were eager to share their knowledge of what is going well in the implementation of Aboriginal and Torres Strait Islander health care, and what could be done better. The aims of the roundtable were to:
1. Discuss the current state of implementation in Aboriginal and Torres Strait Islander health care, from the perspectives of Aboriginal and Torres Strait Islander and other health system stakeholders? What do we do well, what could be improved?

2. Share knowledge about what is already known about doing implementation well:
   - evidence from the literature
   - experiential knowledge from practitioners, policy makers and health care providers
   - consider the relevance of implementation literature to Aboriginal and Torres Strait Islander context.

3. Identify priorities for making improvements to the way that new programs and innovations are introduced or transferred from site to site? What do we need to know in order to do better? What are the priorities for action?

The roundtable program juxtaposed presentations about what the evidence says with presentations from Aboriginal community-controlled health sector, government and community settings about direct experience and practice of implementation. The program of presentations and discussions at the roundtable are shown in Table 1, followed by a summary of each presentation.

### Table 1: Roundtable presentations and discussions

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**Summary of presentations**

**What does the evidence say about implementation in Aboriginal and Torres Strait Islander health contexts?**

_Jenny Brands, Menzies School of Health Research_

The academic discipline of implementation science is growing and evidence provides guiding principles to effective implementation, such as the importance of planning, engagement, understanding context, capacity, strategies and adaptation. The core proposition of the evidence is that implementation is likely to be most effective if there is a good fit between the evidence (new practice), context and implementation process.

Yet, current evidence does not say much about implementation in Aboriginal and Torres Strait Islander health, with only 14 studies appearing over the last 20 or so years; nor does it elucidate on how it may differ to mainstream findings. The following elements show where Indigenous evidence might differ from that offered by mainstream health implementation:

- evidence comes from either developed or developing countries while the context of Indigenous health is often a combination of both
- cross-cultural context
- credibility of ‘evidence’
- ideas and practices spread through relationships.

Additional information about the findings from the Implementation of Innovations review of the literature was provided in a briefing paper circulated prior to the roundtable (see Appendix A). This included:

- Credibility: The involvement of Aboriginal and Torres Strait Islander people in the development of an innovation, trust in the ethics and quality of work of the producer of the innovation, and the testing of innovations in local contexts will have a strong bearing on its credibility.
- The spread of ideas about new programs and practices in Aboriginal and Torres Strait Islander health care are highly likely to occur through personal relationships.
- Aboriginal and Torres Strait Islander health care almost inevitably occurs in cross-cultural settings, yet cross-cultural issues have received little attention in implementation science or in organisational development studies more generally. This cross-cultural dimension needs to be included when assessing the organisational context and wider environment for implementation in Aboriginal and Torres Strait Islander health.
- Evidence about implementation comes largely from highly developed countries, or, from developing countries. Aboriginal and Torres Strait Islander health care takes place in a setting that has characteristics common to both developed and developing countries, so care needs to be taken in applying what has been learned directly from either field of study.
- Building the long-term capacity of organisations to support innovation is likely to be more attractive and more cost-effective than simply supporting the implementation of a particular innovation.
- Some innovations may diffuse inequitably, spreading unevenly across different settings, or bringing greater benefit to the already advantaged. Well -resourced, mature organisations and communities are able to draw greater value from an innovation than those with underdeveloped structures and few resources. We need strategies to ensure the fair and equitable implementation of innovations.
• Health services and systems are complex adaptive systems, with ongoing change and multiple components interacting. Most of what they do has at one stage been an innovation. The influences of change over time (sustainability, adaptability) and the aggregation of innovations in a workplace or setting are also important aspects of implementation that we need to understand better.

The Institute for Urban Indigenous Health (IUIH): Facilitating implementation in Indigenous health care

Alison Nelson (in preparation with Renee Blackman, who was unable to attend), IUIH

IUIH aims to increase health services access and opportunities, providing coordination and support for Aboriginal and Torres Strait Islander health service development across the South East Queensland region. Key areas of operation are service development, workforce development, targeted preventative health campaigns, working closely with mainstream services, and research.

The IUIH model helps services to determine the needs of their own community, and become masters of their own destiny, using the following strategies:

• Focus on systems – health services need systems in place to make best use of opportunities
• Formal assessment of local context – followed by training to close gaps in knowledge
• Clearly defined functions and roles, which are critical in making the whole system work
• Guide and then step back while continuing to provide incentives to keep achieving results.

IUIH trains health professionals to work with Aboriginal and Torres Strait Islander people to help them manage their chronic disease through programs such as ‘Work it out’. Evaluation of the program has revealed elements that facilitate implementation and sustainability:

• The importance of the social and psychological aspects of the innovation
• Participants commitment, growing independence and trust
• Promotion of the program, especially engaging participants as champions of the program
• Flexible and non-prescriptive approach
• Tailored to each individual and setting
• Evaluation and feedback of results; sharing knowledge and providing incentives.

Implementation science to enable uptake of better practices and service models for Indigenous health

Professor John Øvretveit, Karolinska Institutet, Stockholm

The cost of the failure to implement effective practices in health is a loss across all areas of life – not only money, but practice, connectedness and relationships. Finding effective ways to enable the uptake of change is complicated, as there is no general implementation guide or common context in which to implement. A common cry of ‘it depends’ at the Roundtable underlines the complexities involved.

Research informed principles and knowledge offer a starting point to understanding effective implementation, such as:

• The MASTeR behaviour change model
  o Motivation – keep thinking about the benefits and envision a better future
  o Abilities – build skills and create a supportive environment
The successful transfer of the grass roots Program is facilitated by the following elements:

- The Program’s openness to adaptation making it easy to take out the parts needed for different types of program areas
- The Program is experiential and empowering, enabling people to take control of the process
- A core process of ‘supporting inside-out empowerment by embracing relatedness’. The empowerment of the self and then the community enables people to embrace their

How a government agency actively facilitated the implementation process in Victorian primary health care. Case study: Primary Care Partnerships

Jenk Akyalcin, (formerly) Department of Health, Victoria

Primary Care Partnerships (PCPs) have successfully brought a diverse range of agencies together to improve a community’s access to health services and provide localised care. If an organisation can see value in the innovation then they will come to the table and put their voice out to others – seeing value thus encourages sustainability. The aim is not only to exchange information but solve problems together over time.

PCPs have enabled service coordination changes: an increase in integration, common ways of practice, standardisation and use of information technology. Currently the Victorian state government funds 30 PCPs (see <http://www.health.vic.gov.au/pcps/about/index.htm>).

These effective changes to service systems occurred by:

- Challenging people with the evidence
- Government working with service providers and providing funds to learn new skills
- Providing direction on a work logic with clearly defined roles, thus allowing a common way of seeing the world but with flexibility
- Measuring progress and CQI, which sees data change into shared information
- Development and training around practice changes.

‘Bigger than a program’: the transfer of the Aboriginal Family Wellbeing Program across Australia

Janya McCalman, James Cook University

The Aboriginal Family Wellbeing Program uses a community development approach to support Aboriginal people to meet their higher needs and thus their wellbeing and capacity to work. The spread of the Program from its origins in Adelaide to every Australian state and territory, and beyond to Papua New Guinea, Ghana and Canada, is a rare description of successful program transfer in the Indigenous Australian health literature.

The successful transfer of the grass roots Program is facilitated by the following elements:

- The Program’s openness to adaptation making it easy to take out the parts needed for different types of program areas
- The Program is experiential and empowering, enabling people to take control of the process
- A core process of ‘supporting inside-out empowerment by embracing relatedness’. The empowerment of the self and then the community enables people to embrace their
relatedness to self, others and structural conditions at the individual and organisational level
• Support from collaborations, partnerships and informal networks along with the value adding role of research
• ‘When people have knowledge, skills and resources they will act in their own best interests’.

Implementing cultural programs in Tasmanian schools: challenges and successes

Theresa Sainty, Aboriginal Educator, Tasmania

A Tasmanian Aboriginal community were the drivers of a cultural education program and its implementation because they could not see themselves included in the broad picture of Aboriginal Australia. Evidence of the program’s success can be seen in the pictures of children involved in cultural activities that increased their sense of self and Aboriginal identity.

Challenges faced throughout this innovative process of implementation:

• The racist attitudes of mainstream Australia and debunking the myths that they uphold
• How to share information and stories in keeping with cultural protocols
• Evaluation as an onerous task that, without additional resources, takes the focus off the client to the document, which can impact the quality of the program.
• Concerns that researchers do not understand what the community needs and that the most important evidence of success, such as a child’s increased sense of self, is not easily measured.

Enablers of implementation focused on community strengths and knowledge:

• A focus on learning about culture through specific activities
• Elders and community as holders of cultural knowledge
• Being on Country
• Aboriginal education officers
• Cultural awareness training for non-Indigenous teachers – e.g. on Country with community.

Support for implementers

Professor John Øvretveit, Karolinska Institutet, Stockholm

Support for implementers, or changers, is about enabling people to take part. The process of designing the right support does not involve assumption, and should always begin by asking people what they need, if anything, to make change happen. To fully understand the support required explore what job is has to do and what people would do without support.

Explore which support is needed at each of the following steps to implement ‘better ways’:

1. Form an ‘implementation organisation’ or team of changers (people who require change and their helpers)
2. Choose a resolvable problem that many agree needs fixing
3. Find potential solutions with evidence or experience
4. Assess the cost of making the change, and savings that will be made, to determine if implementable and sustainable
5. Package the solution in a form usable by changers
6. Changers adapt the package to suit their context
7. Changers receive feedback on their success and revise
8. Share new knowledge and help others.
Key issues arising from the roundtable

The roundtable identified a number of important issues that should be taken into account when considering implementation in Aboriginal and Torres Strait Islander contexts which differ from the focus or emphasis of the literature on implementation more broadly.

These issues included:

- Recognising different viewpoints and forms of evidence and knowledge in selecting and implementing ‘new better ways of doing things’
- Taking a collaborative approach to planning and doing implementation
- Learning from each other and supporting innovation exchange (instead of holding information back from fear of competition or ‘risk management’)
- Building enabling systems and the capacity of organisations to implement change
- Communicating change with a clear program logic of what is being done and why
- Understanding what the local context means for the process of innovation
- Applying and upholding basic principles of social justice, for example, ensuring that implementation processes provide equivalent benefit across the health system or across society, rather than increasing the gap between high performing organisations/communities and those organisations or communities that are struggling.

Summary

In wrapping up the roundtable, Mick Gooda said: ‘We asked the question ‘Can we do implementation better?’ I think what we’ve heard today is that we don’t have a choice – we have to do implementation better. And that we can do it.’
Acknowledgments

The Implementation of Innovations in Aboriginal and Torres Strait Islander Health Care project team includes Kate Silburn, La Trobe University (project leader); Jenny Brands (project manager) and Alana Gall (research assistant and administration support), Menzies School of Health Research; and Luella Monson-Wilbraham (research assistant), the Lowitja Institute.

Thank you to:

- Alana Gall for organising and managing the event impeccably
- John Øvretteit for helping prepare the pre-roundtable briefing paper, feedback on the literature review and his inspiring presentations on the day
- All the other presenters who so generously shared their time and knowledge:
  - Alison Nelson, Institute of Urban Indigenous Health
  - Janya McCalman, James Cook University
  - Jenk Akyalcin, formerly Victorian Primary Care Partnerships, Victorian Health Department
  - Theresa Sainty, Tasmanian educator
- Vivian Lin, La Trobe University, for summarising key points from the discussions
- Mick Gooda, Aboriginal and Torres Strait Islander Social Justice Commissioner, for facilitating the roundtable and contributing his experience
- All the participants at the roundtable who participated so enthusiastically in all the discussions

And the Lowitja Institute for supporting the project, particularly Lowitja Institute Program Manager Liz Izquierdo who has helped see the project to completion and was disappointed she couldn’t attend the roundtable.
Can we do implementation better?

Briefing paper

Applying evidence to the implementation of new programs and innovations in Aboriginal and Torres Strait Islander health care

Summary notes by Jenny Brands and John Øvretveit, March 2013

What is implementation?

• Implementation is the process of getting a ‘new better way’ of doing something into routine use.
• Implementation enables a person or organisation to take up the new better way of doing something.

Why is implementation important?

• Money, effort and time are wasted by ineffective implementation of new programs.
• Programs and practices that work well in Aboriginal and Torres Strait Islander health often lapse after pilot programs or research funding ends.
• Doing better at implementation could help ‘Close the Gap’ more rapidly.

What do we know about implementation in Aboriginal and Torres Strait Islander health?

• In terms of an evidence base, not a lot. A recent review found only 14 studies published between 1992 and 2011 that evaluated or described the transfer and implementation of promising programs or innovations in Aboriginal and Torres Strait Islander health (McCalman et al. 2012). But the nature of Aboriginal and Torres Strait Islander health care means that lots of people are doing implementation all the time. Some people and organisations do it very well; others struggle.
• To help build an evidence base about effective implementation, the Lowitja Institute commissioned a research project, Implementation of Innovations in Aboriginal and Torres Strait Islander Health Care. So far, the project has included a review of the academic literature on implementation in health care generally, and how that literature might be relevant in Aboriginal and Torres Strait Islander health contexts.

What do we know about implementation generally?

There are a number of principles that emerge from the academic literature as enablers of effective implementation.

Planning

Using a planned and participatory approach to implementation – involving and engaging people from across the organisation/setting(s) in which the implementation will occur, at all stages of the process

Engagement/leadership

Strong engagement in the whole implementation process by leaders and managers.

Building a shared meaning about the change that is being implemented.
Context
Giving adequate consideration to the specific nature and priorities of the local context when planning implementation and reducing any barriers that may impede effective implementation – taking note that local context is influenced by inner (organisational) and external (wider setting) environments and issues.

Strategies
There are many implementation strategies that can be used (see below: Implementation Strategies). There is no magic bullet – strategies need to be selected to suit the change you wish to make, the local context and the resources or capabilities you have.

Using multiple strategies for implementation is likely to be more effective (up to a point).

Adaptation
Adaptability of innovations to suit local contexts in ways that will support adoption without losing core components – including the way that innovations are ‘packaged’.

Capacity
Organisational capacity to take on innovations (also called ‘absorptive capacity’) – this requires human and financial resources, along with facilitation. It includes organisational capacity to be innovative – using implementation as an opportunity to build the longer-term capacity of an organisation or community to create and implement innovations that suit local needs and context.

A sense of self-efficacy or empowerment amongst individuals and groups.

The implementation evidence-base and Aboriginal and Torres Strait Islander health care
• Credibility: The involvement of Aboriginal and Torres Strait Islander people in the development of an innovation, trust in the ethics and quality of work of the producer of the innovation, and the testing of innovations in local contexts will have a strong bearing on its credibility.
• The spread of ideas about new programs and practices in Aboriginal and Torres Strait Islander health care are highly likely to occur through personal relationships.
• Aboriginal and Torres Strait Islander health care almost inevitably occurs in cross-cultural settings, yet cross-cultural issues have received little attention in implementation science or in organisational development studies more generally. This cross-cultural dimension needs to be included when assessing the organisational context and wider environment for implementation in Aboriginal and Torres Strait Islander health.
• Evidence about implementation comes largely from highly developed countries, or, from developing countries. Aboriginal and Torres Strait Islander health care takes place in a setting that has characteristics common to both developed and developing countries, so care needs to be taken in applying what has been learned directly from either field of study.
• Building the long-term capacity of organisations to support innovation is likely to be more attractive and more cost-effective than simply supporting the implementation of a particular innovation.
• Some innovations may diffuse inequitably, spreading unevenly across different settings, or bringing greater benefit to the already advantaged. Well -resourced, mature organisations and communities are able to draw greater value from an innovation than those with
underdeveloped structures and few resources. We need strategies to ensure the fair and equitable implementation of innovations.

- Health services and systems are complex adaptive systems, with ongoing change and multiple components interacting. Most of what they do has at one stage been an innovation. The influences of change over time (sustainability, adaptability) and the aggregation of innovations in a workplace or setting are also important aspects of implementation that we need to understand better.

**Implementation Strategies**

**John Øvretveit’s list of evidence-based implementation strategies**

(John Øvretveit, Karolinska Institutet, Sweden jovretbis@aol.com)

**Strategies directed at the individual**

1. Show the patient’s experience
   The patient talks about their experience with the old way; another or same patient talks about their experience with the new way.

2. Show the money
   Financial incentives for new behaviours: extra income or loss of income, one-off payments for eg education or changes to computer systems.

3. Show the results (of the new way)
   Routine, timely feedback on compliance or performance in visual and comparative display. Presenting feedback in terms of time saved or the value of the results to the individual or patient (posted daily at main work place centre, eg ‘days since last blood stream infection’).

4. Training which involves practising new behaviour, with guidance-feedback (eg simulation)

5. Activating patients or carers to expect and ask for the new way of working:
   For example, in the patient’s hospital admissions materials: ‘Our staff wash hands before touching you: ask them if they have washed their hands or wear this badge’.

6. Summaries or visual ‘job aids’ at the point of care (simple 1 page)

7. Reminders

8. Peer-based enabling sessions (ideally led by respected leader)

9. Leader actions
   Motivational talks, individual coaching, modelling the new behaviours so all see or hear that they practice it (opinion leaders, clinical champions).

10. Facilitator/coach support
    Academic detailing visits or sessions (on-site, one on one or group discussion about an innovation’s use in local setting), easy access to expert to ask questions (eg. quick telephone support).

11. Management actions:
    Supportive supervision; escalating levels of disciplinary action for non-compliance; creating supportive environments using the ‘indirect strategies’ listed below.

12. Education or training

13. Showing the evidence (of benefit)
    Show how the change has led to benefits elsewhere compared to how things are done now, through media likely to be read by the individual such as professional journal, newsletter, on-line or conventionally or through other media

**Indirect strategies – changes to the environment**

Strategies to create conditions supporting the new behaviours, and to remove barriers.

1. **Changing organisation** to enable or reinforce new behaviours
• Changing work-flow or information-flow
• Providing support staff to take over some tasks, so as to release time for others to learn or practice the new behaviours

2. Changing systems to enable or reinforce new behaviours
• Changing IT to give reminders at point of care or easy access to information relevant to the new behaviour
• Providing support expertise

3. Changing physical environment of practice to enable or reinforce new behaviours
• Changing organisation or workflow, reducing noise and interruptions

4. Higher level changes
• Regulatory (eg accreditation standards, licensing changes)
• Financial (reimbursement or grants)
• Policies of professional or organisational associations and ‘good practices’ documents including clinical guidelines

Making these strategies work

The effectiveness of each type of strategy depends on:

• the type of change you are aiming for: eg to enable people to implement a new effective diabetes management method, or a new computer decision support, or a falls prevention strategy in a nursing home, or a procedure to reduce post-surgical infections, etc) (‘fit’ with local needs, context, relevance, complexity)
• how completely or effectively the strategy is carried out (eg delays in finance slowed the IT system changes needed for the implementation)
• whether the change is adapted as a part of implementation (some strategies are better for enabling a proven treatment or model to be copied exactly in routine work, others are better for enabling adaption of the treatment or model to patients, context and available resources, then checking if it is still effective).
• the particular method used within each type of strategy, within the categories listed (eg education can be done through active problem based adult learning, rather than by lecture; or feedback by showing performance every day visually on a graph, with comparative performance, rather than providing a printout of numbers every month).
• features of the setting and environment, including expectations, motivations and prior experience of the people, group or organisation ‘taking up’ the ‘new way’.

Note: Implementation approach is more than just selecting a strategy. It combines structure (who is responsible for leading the change, who do they report to?), systems (methods for supporting the people changing and measuring what has changed), and the strategy actions taken in different stages (implementation process).

Measuring implementation

• What will you see if the process of implementation is a success, and how can you measure this? (final outcome metrics)
• What will you see at different times if the process of implementation is progressing successfully, and how can you measure progress and milestones? (progress metrics)

For more information, John Øvretveit’s ‘Implementation strategies and planning implementation for improving health’ is available from Jenny Brands.